State of Montana
ffice of the Legislative Auditor

Performance Audit

ADMINISTRATION OF MEDICAID FEE-BASED SERVICES PROGRAM

Department of Social and Rehabilitation Services

PLEASE RETURN

This report contains conclusions and recommendations for changes in the operation and management of the Medicaid fee-based services program. The recommendations include:

► Place a high priority on implementing management controls for the Medicaid Services Bureau.

► Initiate more contact with fee-based providers.

Office of the Legislative Auditor
Room 135, State Capitol
Helena, Montana 59620

85P-10

PERFORMANCE AUDITS

Performance audits conducted by the office of the Legislative Auditor are designed to assess state government operations. From the audit work, a determination is made as to whether agencies and programs are accomplishing their purposes, and whether they can do so with greater efficiency and economy. In performing the audit work, the audit staff uses audit standards set forth by the United States General Accounting Office.

Members of the performance audit staff hold degrees in disciplines appropriate to the audit process. Areas of expertise include business and public administration, statistics, economics, computer science, and engineering.

Performance audits are performed at the request of the Legislative Audit Committee which is a bicameral and bipartisan standing committee of the Montana Legislature. The committee consists of four members of the Senate and four members of the House of Representatives.
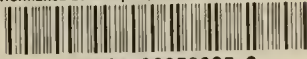

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PERFORMANCE AUDIT REPORT

ADMINISTRATION OF MEDICAID FEE-BASED SERVICES PROGRAM
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

September 1985

Report Number 85P-10

STATE OF MONTANA

Office of the Legislative Auditor

STATE CAPITOL
HELENA, MONTANA 59620
406/444-3122

SCOTT A. SEACAT
Acting Legislative Auditor

August 1985

The Legislative Audit Committee
of the Montana Legislature:

This is our performance audit of the Administration of the Medicaid Fee-Based Services program of the Department of Social and Rehabilitation Services.

This report contains conclusions and recommendations concerning department procedures in relation to administration of the Medicaid Fee-Based Services program. Department responses are contained at the end of the report.

We wish to express our appreciation to the staff of the department for their cooperation and assistance.

Respectfully submitted,

Scott A. Seacat
Acting Legislative Auditor

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ADMINISTRATIVE OFFICIALS

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Dave Lewis, Director

Benjamin F. Johns, Deputy Director

ECONOMIC ASSISTANCE DIVISION

Lee Tickell, Administrator

SUMMARY OF RECOMMENDATIONS

The following is a listing of recommendations of our performance audit of the administration of the Medicaid fee-based services program. The major issues discussed in the report relate to the need to strengthen management controls within the Medicaid Services Bureau and the need for the bureau to initiate more contact with fee-based providers.

SRS's response to each recommendation follows the recommendation. SRS concurred with each recommendation. See indicated page numbers for additional information related to each area. See Chapter II for an overview of the Montana Medicaid program and for background information on the fee-based services program.

CHAPTER III

BUREAU MANAGEMENT (page 12)

We reviewed administrative procedures of the Medicaid Services Bureau. We identified several areas where management controls could be strengthened within the bureau.

RECOMMENDATION #1 (page 16)
WE RECOMMEND THE DIVISION PLACE A HIGH PRIORITY ON THE FOLLOWING FOR THE BUREAU:
A. DEVELOPING FORMAL GOALS AND OBJECTIVES;
B. DEVELOPING POLICIES AND PROCEDURES;
C. IMPLEMENTING ANNUAL PERFORMANCE EVALUATIONS;
D. DEVELOPING A REPORTING SYSTEM TO MANAGE TIME WORKED, AND;
E. UPDATING EXISTING JOB DESCRIPTIONS.

Agency Response: Concur (page 33)

CHAPTER IV

ALLOWABLE RATE AND SERVICES (page 17)

SRS CLAIM REVIEW (page 25)

We found that the bureau does not maintain records of the number and types of by report claims that are reviewed by each administrative officer. Collection of this information would allow for the establishment of a fee for those services which have become more common place and no longer need individual review.

RECOMMENDATION #2 (page 26)

WE RECOMMEND THE BUREAU MONITOR THE NUMBER AND TYPES OF BY REPORT PROCEDURES REVIEWED BY THE ADMINISTRATIVE OFFICERS.

Agency Response: Concur (page 33)

CHAPTER V

PROVIDER SERVICES (page 28)

DEPARTMENT'S ROLE IN PROVIDER RELATIONS (page 30)

SRS has no system to routinely collect provider information and comments.   The department's contact with providers is primarily reacting to provider problems and inquiries.   We found that providers had many concerns with the Medicaid program and also had suggestions to improve the fee-based system.

RECOMMENDATION #3 (page 31)

WE RECOMMEND THE MEDICAID SERVICES BUREAU INITIATE MORE CONTACT WITH FEE-BASED PROVIDERS TO IMPROVE THE MEDICAID FEE-BASED SYSTEM.

Agency Response: Concur (page 33)

CHAPTER I

INTRODUCTION

A performance audit of the administration of the Medicaid fee-based services program of the Department of Social and Rehabilitation Services (SRS) was approved by the Legislative Audit Committee after a preliminary survey of the Medicaid program was presented to the committee in June 1984. Fee-based services include physician, dentist, pharmacy, and any other noninstitutional Medicaid service, excluding home health care. This report summarizes the results of our performance audit.

OBJECTIVES OF AUDIT

The three main objectives of this audit were:

1. To determine if the Medicaid Services Bureau is administered in an effective and efficient manner.

2. To determine if procedures used to set reimbursement rates are reasonable.

3. To determine if procedures used to inform providers of such things as rates and allowable services are effective.

In addition, this report is intended to present independent information on how the Medicaid program is managed by SRS and how the program functions in Montana. We have included this aspect in our report because of the many parties who are concerned with Medicaid and because of the need to understand program terms, coverage, and funding.

SCOPE OF AUDIT

The audit focused on the administration of the fee-based services program by the Medicaid Services Bureau of SRS. This area is the third of five areas of the Medicaid program our June 1984 survey identified as feasible for audit. During this audit, the department contracted with a new fiscal agent to process Medicaid claims. We are currently reviewing the effect of this

change in a separate audit and will report any concerns at a later date.

The audit was conducted in accordance with generally accepted governmental performance auditing standards. The audit did not include a review of the financial status of the department.

As a part of our audit we reviewed the administrative procedures used by the Medicaid Services Bureau. The Medicaid Services Bureau also administers the Home and Community-Based Services Program. Because the Home and Community Based Services Program is not strictly fee-based, we have presented the results of our audit for this area in a separate report.

We reviewed the allowable rates and services provided by the program and evaluated the reimbursement process. This included a review of provider fee levels in comparison with billed charges. We evaluated the procedures used to approve new services.

We distributed over 700 questionnaires to a sample of providers to identify their concerns regarding rates, co-payments, allowable services and processing of reimbursements. We reviewed procedures used to enroll new providers and evaluated the effectiveness of the relationships between the department's fiscal agent, the department, and providers.

Our sample was randomly selected from an active provider list as of August 1984. We sampled only fee-based providers and, therefore, excluded hospitals and nursing homes. We recorded 478 questionnaire responses.

A sample of nonrespondents was also contacted by telephone to determine why questionnaires were not returned. The main reasons for nonresponse included time restraints and providers who had retired during the last few years and therefore did not feel informed enough to answer the questionnaire. Respondent types are shown in the following illustration.

QUESTIONNAIRE RESPONDENTS BY PROVIDER TYPE

Provider Type	Frequency of Responses	Percent of Responses
Physician	185	38.7
Dentist	86	18.0
Group Physicians	46	9.6
Pharmacy	45	9.4
Personal Care Attendant	22	4.6
Optometrists	20	4.2
Ambulance	17	3.6
Medical Supplies	12	2.5
Psychologists	10	2.1
Other	35	7.3
Total	478	100.0

Source: Compiled by the Office of the Legislative Auditor

Illustration 1

We received responses from providers in 42 counties plus providers from out of state. See Appendix A for the tabulation of question-naire results.

COMPLIANCE

    As part of our audit we reviewed compliance with laws, administrative rules, and policies relating to the administration of the Medicaid fee-based services program. Significant instances of noncompliance with laws, rules, or policies were not found during our examination. For items we did not specifically test for compli-ance, nothing came to our attention that would indicate significant instances of noncompliance.

CHAPTER II

BACKGROUND

Medicaid is an economic assistance program designed to provide medical services to the poor. The program has two major goals: 1) to ensure that health care is available to those who otherwise could not afford it, and 2) to improve people's health and thus reduce their dependence on other forms of public aid.

This chapter provides: 1) a brief history of the Medicaid program and recent changes that affect the fee-based services provided; 2) a definition of fee-based services and comparison of the expenditures in this area to the overall expenditures in Medicaid; 3) an overview of the administration of fee-based services; 4) a description of the roles of the Department of Social and Rehabilitation Services, providers and outside contractors; and 5) an overview of where administration of fee-based services fits into the SRS organization.

HISTORY

The Montana Medicaid program was established in 1967 as a federal-state partnership with the federal government providing financial support and basic program guidelines. SRS administers the program but must provide specific care requirements set forth by the federal government in order for the state to receive matching funds.

With its inception in Montana, only basic services were offered by Medicaid: hospitalization, physicians, skilled nursing home care, prescription drugs and dental. In 1968, optional services such as intermediate care facilities, medical equipment and treatment by optometrists and podiatrists were included.

FEE-BASED EXPENDITURES

Medicaid fee-based expenditures are jointly funded by federal and state governments. The rate of federal financial participation is calculated from a formula using the state's per capita income and the national average per capita income. The federal participation

rate for Montana was approximately 64 percent for fiscal year 1984-85.

Expenditures for fee-based services account for approximately 23 percent of the total Medicaid benefit expenditures in fiscal year 1983-84. Fee-based expenditures make up all providers except hospitals, nursing home care, and home and community-based services. Illustration 2 shows the total Medicaid benefit expenditures as compared to fee-based service expenditures for fiscal years 1981-82 to 1983-84 (includes both state and federal money). In addition, the state expended $5.2 million for Medicaid administration in fiscal year 1983-84.

MEDICAID BENEFIT EXPENDITURES
Fiscal Years 1981-82 Through 1983-84
(In Millions of Dollars)

TOTAL MEDICAID EXPENDITURES
FEE-BASED MEDICAID EXPENDITURES
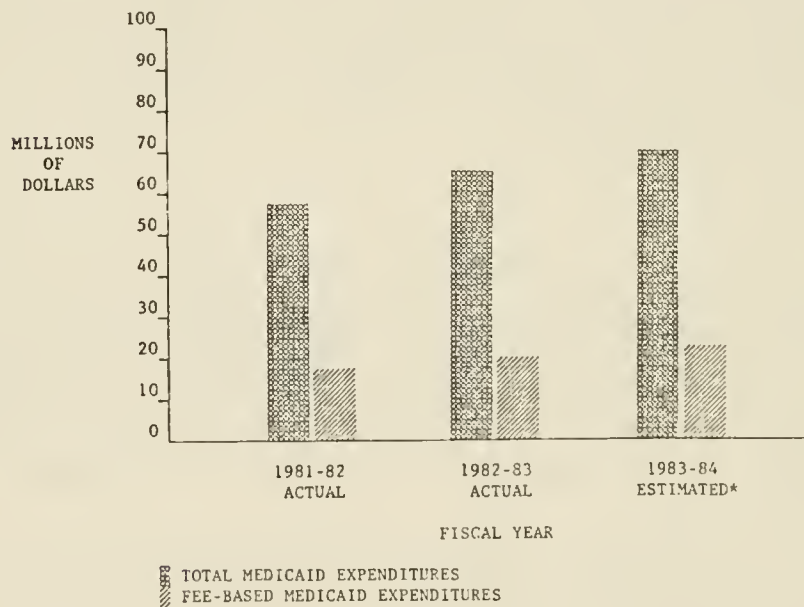
*NOT ALL CLAIMS HAVE BEEN PROCESSED FOR SERVICES PERFORMED DURING FISCAL YEAR 1983-84.

Source: SRS Statistical Reports and Date of Service Reports

Illustration 2

FEE-BASED PROVIDERS

The federal government requires that all participating Medicaid states offer mandatory services to receive federal financial

participation. Montana offers all mandatory services. The follow-
ing illustration lists mandatory and optional fee-based services
allowed by Montana.

FEE-BASED SERVICES ALLOWED BY MONTANA MEDICAID

Mandatory Services	Optional Services	
1. Lab and X-Ray Services	1. Dental	10. Occupational Therapy
2. Family Planning Services and Supplies	2. Dentures	11. Psychological Services
	3. Prescription Drugs	12. Personal Care Attendants
3. Early and Periodic Screening, Diagnosis, and Treatment	4. Rehabilitative Services	13. Private Duty Nursing Services
	5. Podiatrists	14. Clinic Services
4. Physician Services	6. Optometrists	15. Audiology Services
	7. Eyeglasses	16. Medical Transportation
	8. Physical Therapy	17. Prosthetic Devices
	9. Speech Therapy	18. Other Practitioners

Source: Health Care Finance Administration

Illustration 3

Fee-based services are delivered through various in-state and
out-of-state private practitioners. Approximately 3,700 fee-based
providers were enrolled in the Medicaid program in fiscal year
1983-84. About 89 percent of enrolled providers participated by
rendering services in fiscal year 1983-84 (see Illustration 4).

Provider Type	Number of Enrolled Providers	Number of Providers Participating
Physician	1,677	1,481
Optician	47	40
Optometrist	152	144
Psychologist	33	32
Podiatrist	22	22
Occupational Therapy	36	32
Physical Therapy	71	60
Speech Therapy	38	31
Pharmacy	290	288
Dentist	524	500
Lab/X-ray	29	25
Other	790	652
Total	3,709	3,307

Source: MARS Report (March 1985) for FY 1983-84

Illustration 4

The "other" provider type includes ambulance services, medical equipment providers, personal care attendants, audiologists and miscellaneous other service providers.

Physicians make up the largest group of fee-based providers. Most physician services are covered by Medicaid. Some common limitations for physician services include:

- sterilization/abortions limited by federal regulation;

- experimental services; and

- cosmetic services unless severe impairment to patient's psycho-social well-being is demonstrated and treatment has prior authorization.

Recipients of physician services are responsible for a co-payment of $1.00 per service. This payment is subtracted from the allowable reimbursement paid by Medicaid to providers.

Prescription drugs are another large component of fee-based services. Any drugs dispensed must be prescribed by a doctor.

Experimental drugs are not covered. Recipients are responsible for a co-payment of $.50 per prescription.

Another area covered through the fee-based services program is dental services. Extensive dental services must have prior authorization. Extensive work is considered to be crowns, bridges, dentures, root canals, and all orthodonture. Recipients are responsible for a co-payment of $1.00 per service.

Illustration 5 shows the relative percentage of claims processed and money expended for each type of fee-based provider.

MEDICAID CLAIMS
Fiscal Year 1983-84

PERCENT MONEY EXPENDED

DRUGS (21.6%)
DENTAL (10.8%)
OTHER PRACTITIONERS (7.0%)
PHYSICIANS (30.0%)
OTHER (30.6%)

PERCENT CLAIMS PROCESSED

OTHER (14.7%)
OTHER PRACTITIONERS (3.1%)
DENTAL (4.2%)
PHYSICIANS (20.3%)
DRUGS (57.7%)
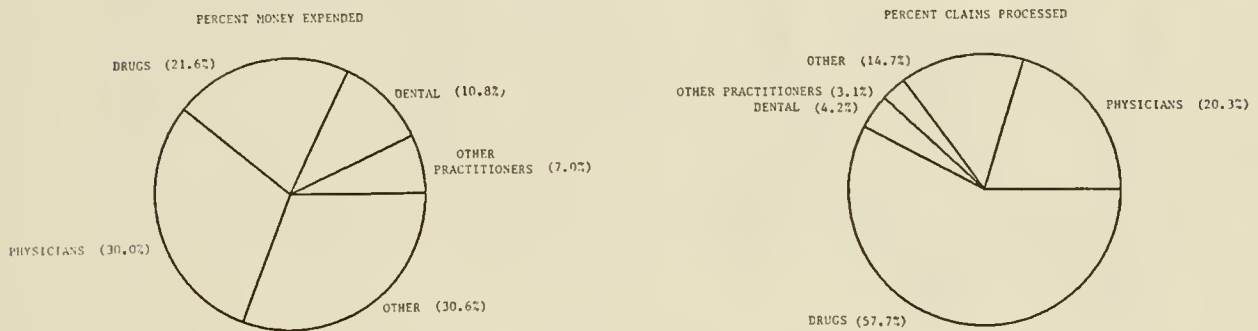
Source: SRS Date of Service Reports and MARS Reports.

Illustration 5

PROVIDER REIMBURSEMENT

A fee schedule was developed by Medicaid Services Bureau personnel and included in the Administrative Rules of Montana (ARM). This same schedule is included in the provider manual sent to fee-based providers. Bureau personnel maintain the fee schedule and work through a fiscal agent to notify providers of updates and changes.

Over 7,500 procedures are listed in the ARM. The majority of these procedures have specific dollar amounts that will be paid to Medicaid providers. Approximately 40 percent of fee-based procedures are listed as "by report" (BR) items. By report items

are procedures infrequent or unusual in nature. Claims received for BR items are either handled directly by the fiscal agent or reviewed and authorized by bureau personnel before payment. Total BR claims reviewed by bureau personnel are approximately one-half of one percent of total claims processed.

Rates for prescription drugs are not listed in the ARM. Prescription drugs are reimbursed at the cost of the drug plus a dispensing fee for handling costs. The cost of the drug is determined by "American Druggist Blue Book Data Center" and updated monthly. Each pharmacist enrolled in the Montana Medicaid program receives a microfiche copy of the blue book rates.

For all the procedures listed on the fee schedules, the Medicaid program will pay the lower of the following: 1) the Medicaid rate; 2) the Medicare rate (if the procedure is covered by Medicare); or 3) the provider's usual and customary charge for the service. By report items are paid between 65.2 percent and 90 percent of actual (submitted) charges, or the Medicare rate, whichever is lower.

MMIS

The Medicaid Management Information System (MMIS) is the major source of data for the Montana Medicaid Program. MMIS is an automated data processing system used to pay Medicaid claims and to report on claims activity. During fiscal year 1983-84, MMIS was administered by a private fiscal agent through a claims processing office in Great Falls, Montana, and a computer processing office in Albuquerque, New Mexico. As of March 1, 1985, the Department has contracted with a new fiscal agent. Claims processing is now done in Helena with the computer processing office in Atlanta, Georgia.

INPUT OF ALLOWABLE FEES AND COSTS

The fiscal agent is responsible for the input of all usual and customary fees allowed by Montana. Fees were originally input into the MMIS dependent on SRS and federal guidelines. As

increases or decreases are given by the state, fee changes are made. No increase in fee-based services (physicians, dentists, etc.) has been authorized since July 1982.

Input of drug information is performed primarily through SRS' subscription to the "American Druggist Blue Book Data Center." The service provides a magnetic tape to the fiscal agent containing all updates on new drugs and price changes. The National Drug Code is used to identify each drug. Providers are paid on a "per dosage" basis.

FISCAL AGENT

The providers initial contact with the Medicaid program is made with the fiscal agent. The fiscal agent receives letters and telephone calls from providers requesting admittance to the Medicaid program. The agent may also receive claims for services from providers who are not yet enrolled in the program. When any of these instances occur, the fiscal agent sends an application to be filled out by the provider. Upon receipt of the completed application a confirmation form is sent to the appropriate licensing board. If the candidate is found to be a licensed provider, the fiscal agent assigns a provider number, enters the pertinent information into MMIS and mails precoded claim forms along with a manual to the new provider.

The fiscal agent processes all claims, provides a paid claims tape to SRS, and performs all the duties necessary to operate and maintain the Medicaid Management Information System. An additional duty of the fiscal agent involves provider relations. As a part of this duty, the fiscal agent answers questions concerning the status of claims, allowable services, and allowable rates. In addition, the fiscal agent provides annual training workshops for providers.

DEPARTMENT ORGANIZATION

The Economic Assistance Division of SRS is responsible for administering the Medicaid program. The division also administers

other assistance programs such as Aid to Families with Dependent Children and food stamps. The Medicaid Services Bureau within the division represents SRS for most matters relating to fee-based services. As SRS' representative, the bureau is responsible for notifying the fiscal agent of changes in state and federal law and updating applicable manual and ARM sections. The bureau defines the range and limits of reimbursement in the Administrative Rules of Montana. The bureau has 14 staff personnel including the bureau chief, five administrative officers, and eight long-term care specialists.

The administrative officers of the bureau review "by report" claims and authorize the amount of payment. They also review and authorize or deny exceptional or unusual claims, such as experimental procedures. Each administrative officer is assigned the responsibility of administering specific fee-based services. Other duties include establishing reimbursement fees, updating provider information, and evaluating the effect of policy changes. In addition, each administrative officer is assigned special projects. Projects include being the department representative on councils and committees, contract monitoring, and administration of new programs.

The long-term care specialists are responsible for screening nursing home applicants eligible for Medicaid and monitoring the Home and Community-Based Services program in their assigned counties.

CHAPTER III

BUREAU MANAGEMENT

INTRODUCTION

As part of our audit of Medicaid fee-based services, we reviewed administrative procedures of the Medicaid Services Bureau. We identified several areas where management controls could be strengthened within the bureau. Management controls include the organizational plan and policies and procedures needed by personnel to achieve the objectives of the program.

We found that the bureau has not formally established any goals and objectives or developed policies and procedures. We found the bureau lacked updated job descriptions and formal reporting requirements for the administrative officers. In addition, we found the bureau lacked information to evaluate the performance of the program or the staff. We discuss each of these areas in the following paragraphs.

MANAGEMENT CONTROLS

Goals and Objectives

During our initial audit survey of the Medicaid program, it was found that no goals or objectives had been formally developed for the Medicaid Services Bureau. At that time our staff worked with the bureau chief to identify a list of possible goals and objectives. However, since that time the bureau chief stated that there has not been time to consider or formally adopt any goals and objectives.

Goals and objectives would provide direction to bureau personnel and help ensure proper program emphasis.

Policies and Procedures

Policies and procedures of the bureau have not been formally developed. Policies and procedures would provide direction to personnel and define how the agency objectives are to be achieved. For example, the administrative officers are responsible for

approving payment for certain types of claims. Specified procedures would help ensure consistency among the administrative officers and also allow reassignment of claims during vacations and other absences. Formal policies and procedures would strengthen management controls and provide a planning tool for bureau management.

Bureau Organization

At the beginning of our audit we were requested to evaluate bureau staffing levels. Because the bureau has limited documentation of where hours are spent and what activities are performed we were unable to identify staffing needs and work loads.

Part of a strong management control system includes defining organizational responsibilities in order to measure activities and take action to assure goals are being accomplished. Two areas where the bureau could strengthen controls include periodically updating job descriptions and defining reporting relationships within the bureau.

A section of our audit was designed to examine the responsibilities of each administrative officer. We obtained the job descriptions developed for each position. Upon comparing these with actual duties performed, we found three of five descriptions to be inaccurate. The bureau chief has an organization chart of the bureau where he keeps track of assigned duties and projects. The chart is kept current and provides the bureau chief with accurate information. However, updated job descriptions would provide direction to personnel, establish some criteria for performance evaluations, and add formal support for staffing levels.

During our audit we found that the bureau has no formal reporting requirements. Timely reporting of progress would provide management with a tool to assure that the administrative officers are meeting the goals set for the program. Reports would provide management with information to help manage time and assign work loads to bureau personnel.

Evaluation of Performance

Effective management control includes procedures designed to evaluate the performance of staff and program results. Included would be methods followed by management to compare actual performance with planned operations.

Staff Performance

Staff performance should be reviewed and results communicated to each member to assure activities are directed towards meeting the goals of the bureau. Information should be gathered to support staff activity and provide a source for comparison. We believe the bureau could strengthen management controls by conducting performance evaluations and developing procedures to document hours spent by staff on various duties and responsibilities.

The lack of performance evaluations was another concern identified during the initial Medicaid survey. The Medicaid Services Bureau chief praised the value of performance evaluation but indicated he has not had time to implement an evaluation program. The state policy, ARM 2.21.6411, states that performance appraisals should be done of all permanent employees at least annually. Performance evaluations provide direction and ensure that proper guidance is given to employees.

Through interviews with bureau personnel we found information recorded on time summaries to be limited. The staff is required to file a time summary showing compensatory time earned and leave taken. In addition, time spent on the MMIS is recorded separately because it is funded with a higher percentage of federal money. These are the only two sources management has to review the hours spent by the staff. More documentation of where hours are spent would provide better management controls and support existing and requested staffing levels.

Program Performance

Program performance should also be measured as a part of strong management controls. Comparisons of program results with program goals and plans assures that activities of personnel are being directed properly.

We had difficulty evaluating program performance in the area of rate setting because of lack of documentation to support the level where rates were set or methodology supporting rate adjustment. In addition, limited documentation is available to support the work done by the administrative officers including the number of "by report" items approved or reports on the progress of special projects.

We feel that such documentation would strengthen management control. It would add information to help set program goals and provide management with useful criteria to evaluate program results.

Conclusion

A bureau is more effective when personnel have adequate direction and are properly managed. Procedures are more effective when directed towards program goals. Therefore, to assure proper direction and attainment of program goals, good management controls should be established.

As currently managed, bureau personnel are assigned duties and are encouraged to seek help or direction if needed. Policies, procedures and job duties are verbally communicated to staff with no formal reporting requirements.

The responsibility for program management rests with the Medicaid Services Bureau Chief. Specifically the job description states this position: "Plans, organizes, coordinates, and directs the activities of the Medicaid Services Bureau". As mentioned earlier the bureau chief has stated he has not had time to implement some of these management controls. We believe that implementation of these controls should have a high priority. Specifically the Medicaid Services Bureau should consider implementing

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goals and objectives and developing bureau policies and procedures. The bureau should also implement annual performance evaluations, develop a reporting system to manage time worked and periodically update job descriptions. Documentation of program results could also benefit bureau management. Implementation of these recommendations would strengthen management controls and support staffing levels.

The administrator of the Economic Assistance Division has concurred with our observations regarding the establishment of management controls. Department officials indicated that special projects such as establishment of the Home and Community-Based Services program and administration of the Priorities for People program have taken priority over development of these management controls. The division will implement our recommendations as time and resources permit.

RECOMMENDATION #1
WE RECOMMEND THE DIVISION PLACE A HIGH PRIORITY ON THE FOLLOWING FOR THE BUREAU:
A. DEVELOPING FORMAL GOALS AND OBJECTIVES;
B. DEVELOPING POLICIES AND PROCEDURES;
C. IMPLEMENTING ANNUAL PERFORMANCE EVALUATIONS;
D. DEVELOPING A REPORTING SYSTEM TO MANAGE TIME WORKED; AND
E. UPDATING EXISTING JOB DESCRIPTIONS.

CHAPTER IV

ALLOWABLE RATES AND SERVICES

Fee-based providers are reimbursed for services rendered according to preset fee schedules created and updated by the Medicaid Services Bureau. The bureau defines the range and limits for these fees and services in the administrative rules. The rules and guidelines which are developed by the bureau's staff must be used by the various providers who participate in the Medicaid program.

During this portion of the audit, our objective was to:

1. review and document procedures used to establish rates for each type of fee-based service;

2. review and document justification for present fee levels;

3. determine how often provider fees are adjusted;

4. document SRS involvement in reviewing provider claims; and

5. review procedures used to approve allowable provider services.

The following sections discuss these areas.

PROVIDER REIMBURSEMENT RATES

The Medicaid Services Bureau is responsible for setting and adjusting allowable Medicaid reimbursement fees and by report percentages. Each administrative officer monitors specific provider types and performs any rate adjustments for that provider category.

The methodology used in setting reimbursement rates for fee-based providers was not clearly documented by bureau staff. During the audit we hoped to determine whether procedures used to set reimbursement standards and specific rates are reasonable, and how often changes have been made to reimbursement rates. The following sections discuss the lack of documentation and our inability to conclude on those procedures.

Initial Rate Setting

According to bureau personnel, original reimbursement rates were established by using a relative value scale. This consisted of breaking services into particular components and attaching specific weights to each part. These weights were then assigned a value and paid appropriately. In 1980, this process was questioned by the Secretary of State and the Administrative Code Committee as possibly violating the Sherman Anti-Trust Act and section 30-14-205, MCA, as a possible restraint of trade or "price fixing." To resolve this dispute, relative values were converted to dollar figures or specific prices to be paid for each service.

Documentation of rate setting that has been maintained by the staff consists primarily of information on the adoption and amendment of administrative rules as shown in the Montana Administrative Register. The bureau also has the Relative Value Schedule published by the Montana Medical Association. This document was incorporated into the ARM. The bureau has not maintained documentation on their reasoning for the adoption of the relative value schedule. The bureau used several conversion factors to convert the relative values to dollar figures but did not keep their workpapers on how the conversion factors were derived. Some documentation was available concerning methods used to assign dispensing fees for individual pharmacies within the established range. Limited documentation was also available concerning initial fee setting for prosthetics, durable medical equipment, and medical supplies.

Pharmacy Dispensing Fees

Pharmacists receive a "dispensing fee" for each prescription filled (in addition to the price of the drug). The dispensing fee allowed per prescription, ranges from $2.00 - 3.75. This range was set in 1980. Documentation substantiating the reason why the dispensing fee range was set between $2.00 and $3.75 was not available. An individual pharmacist's dispensing fee is determined by the completion of a dispensing fee survey, as required by

federal and state regulations. Based on a pharmacy's revenues and expenses, information gathered from this survey is used to calculate the average cost to dispense a prescription. The individual pharmacist then receives as his dispensing fee, his average cost to dispense plus an incentive factor specified in the department rules.

Prosthetics, Durable Medical Equipment, and Medical Supplies

Limited documentation was available concerning initial rate setting for prosthetics, durable medical equipment, and medical supplies. Reimbursement schedules for these provider areas were first implemented in January 1982 by the Medicaid Services Bureau. Materials utilized to develop these reimbursement schedules included: the fiscal agent's listings of all medical supplies and equipment reimbursed by the Medicaid program, the department's listing of medical supplies and equipment, available Medicare reimbursement rates, and a 1980 medical supplies and equipment retail catalog published by Sickroom Services. Documentation of how these various materials were used to develop the actual fee schedule for these supplies was not available.

By Report Claims

Procedures that are infrequent or unusual in nature (BR claims) are paid at a percentage of actual charges. Physicians' BR claims are reimbursed at 65.2 percent. Podiatrists are reimbursed at 70 percent. BR claims for durable medical equipment, prosthetics, and medical supplies are reimbursed at 90 percent of billed charges. Documentation was not available to justify the percentages used.

Conclusion

The bureau only has limited documentation supporting the methodology used in setting reimbursement rates for fee-based Medicaid providers. Because of this, we were unable to adequately

conclude on the procedures used to initially establish reimbursement rates for fee-based providers.

Adjustments of Reimbursement Rates

Reimbursement rates paid to fee-based Medicaid providers are not adjusted on a regular basis. Some effects of this will be discussed in the next section. There was a prohibition against any fee increases due to an administrative rule effective October 1977 through July 1, 1979. In 1979 the department amended this rule by removing the expiration date and by allowing an exception to the rule. The exception states:

> When it is demonstrated by a professional organization . . . that current Medicaid rates are adversely affecting the program, fee increases shall be granted within legislative budget constraints. . .

We reviewed the fee history (from November 1977 through January 1985) for a sample of procedures. We found that many procedures received 10 percent increases in June 1980 and again in January and June of 1982. There have been no fee increases except for drugs since July of 1982. The following illustration details the most recent changes to fee-based Medicaid provider reimbursement rates.

ADJUSTMENTS OF FEE-BASED PROVIDER RATES

Provider Service	Date of Latest Change in Department Fee Schedule
Podiatry Audiology, Hearing Aids Physicians Optometric, Eyeglasses Psychology Transportation Clinic Physical Therapy Occupational Therapy Speech Therapy Lab & X-Ray Private Duty Nursing	Two 10% increases - January/June 1982
Durable Medical Equipment Medical Supplies Prosthetics	Initial fee schedule established - Jan. 1982
Dental	Increase in selected areas - July 1982
Personal Care	Follows minimum wage laws

Pharmacy:
  Dispensing Fee
  Drugs
	Survey sent in 1983
	Updated monthly

Source: Compiled by the Office of the Legislative Auditor from SRS records.

Illustration 6

Current Reimbursement Rates

We next attempted to determine the adequacy of current fee-based provider reimbursement rates. This evaluation was done through our questionnaire to fee-based providers, by comparing Montana's rates with other states, and by comparing Medicaid reimbursement to providers' submitted charges.

Medicaid rates are substantially lower than the rates billed by the providers. Department records show that physicians are receiving less than 65 percent of their billed rate. Illustration 7

shows the percent reimbursement of normally billed charges for the most common providers.

PERCENT PAID BY MEDICAID OF NORMALLY BILLED CHARGES
Fiscal Year 1983-84
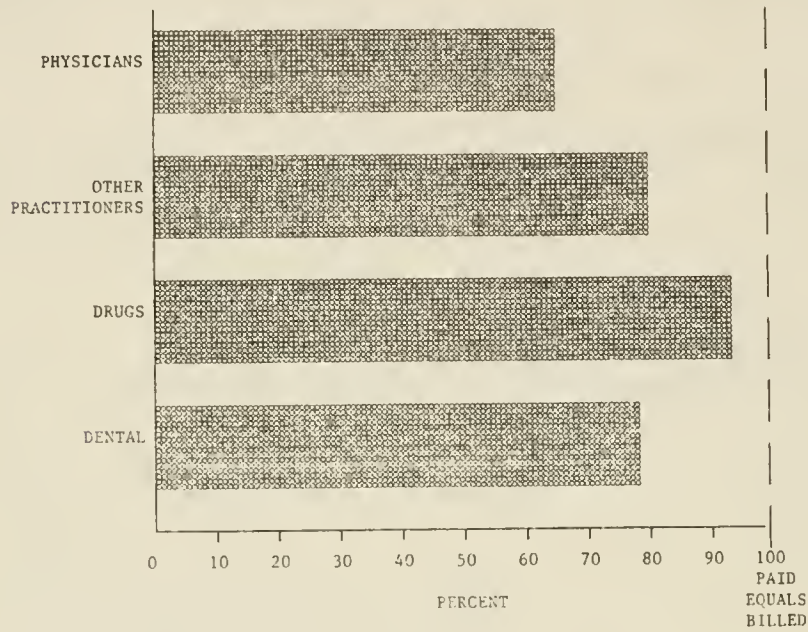
Source: MARS reports (July 1984)

Illustration 7

Even though Montana Medicaid rates are substantially lower than providers' billed charges, they are comparable to Medicaid rates of nearby states. We contacted five neighboring states to find out about their reimbursement rates. We collected information on eight procedures that were high in use, and/or in dollars expended, under Montana's Medicaid program. This information is summarized in Illustration 8.

REIMBURSEMENT OF COMMON PROCEDURES

Procedure Number	Procedure	MT	WY	SD	OR	ID	ND
90050	Office visit for established patient	$15.07	$20.00	$14.00	$14.35	$15.60	$15.00
90010	Office visit for initial visit	28.24	25.00	17.00	26.81	25.80	16.50
90753	Preventive Health Care (ages 5-11)	28.24	20.00	25.00	N/E[1]	M/D[2]	15.00
90841	Medical Psychotherapy	18.84	17.50	15.00	N/C[3]	20.70	18.75
92014	Comprehensive Opthalmological Services	27.98	31.10	29.10	44.82	37.50	29.80
93000	Electrocardiogram	28.24	30.00	25.00	21.45	24.00	29.60
2110	Amalgam Restorations	16.26	20.00	12.50	11.52	13.00	13.00
111	Preventative Diagnostic Services	10.30	12.00	9.00	10.43	10.00	9.00

[1] No fee established

[2] Manually determined

[3] Not a covered service

Source: Compiled by the Office of the Legislative Auditor

Illustration 8

We also compared Medicaid pharmacy dispensing fees with those of nearby states. Montana's dispensing fee is comparable to other western states as shown in the following illustration.

PHARMACY DISPENSING FEE REIMBURSEMENT RATES
Fiscal Year 1983-84

Montana	$2.00 - 3.75
Idaho	2.50 - 3.50
North Dakota	3.75
Oregon	3.40
South Dakota	3.25
Utah	3.25
Washington	3.04 - 3.33

Source: National Pharmaceutical Council Publication

Illustration 9

In addition to a dispensing fee, pharmacists are reimbursed for the allowable price of the prescription. Drugs are reimbursed at "estimated acquisition cost" (EAC), "maximum allowable cost" (MAC), or usual and customary charge, whichever is the lesser amount. Montana subscribes with the "American Druggist Blue Book Data Center" which publishes MAC and EAC drug prices. Most other states also subscribe to either the blue book or a similar drug price reporting service.

Through our questionnaire to fee-based providers, we collected information on providers' opinions on reimbursement rates. Only about 5 percent of those who responded said they were reimbursed at their normal billing rate. On the other hand, nearly 39 percent said they were reimbursed less than half of their normal rates. In addition, it appears that co-payments have effectively further reduced provider rates because, based on our questionnaire, almost 30 percent of the providers are not able to collect co-payments for Medicaid services.

Conclusion

Even though Montana's rates are comparable with other states, there is some dissatisfaction among providers. One reason for this could be that rate increases have not kept up with inflation. The last adjustment to provider rates was in 1982 when rates were increased 10 percent in January and another 10 percent in July. Provider increases have totaled 30 percent since October of 1977. The medical inflation rate has been close to 66 percent from 1977 to now, according to the Consumer Price Index for medical care.

The ARMs allow fee increases (within legislative budget constraints) when medical specialty groups can demonstrate that current Medicaid rates are causing an adverse effect. However, SRS has little direct contact with providers. Providers deal with the fiscal agent to become enrolled in the Medicaid program and when they have questions concerning claims. In Chapter V we address this issue by recommending SRS expand their role in provider relations.

ACCURACY OF CLAIM PAYMENTS

During our audit, we sampled 145 various provider claims to determine if correct payments were made. Claims were sampled for a variety of provider types including: physicians, dentists, pharmacists, optometrists, and therapists. The amounts paid on the claims were compared to the allowable reimbursement amounts as defined in the ARMs. All of the sample claims were reimbursed at the rate specified in the ARMs.

In an earlier Medicaid audit on administrative support functions, we concluded the fiscal agent was accurately and completely inputting allowable fees and costs on the MMIS.

Conclusion

Fee-based providers are being reimbursed at the rates specified in the ARMs.

SRS CLAIM REVIEW

By report claims require action by SRS. These claims are forwarded by the fiscal agent to the administrative officers in the Medicaid Services Bureau for review and approval or denial. Each officer has specific types of providers for which they are responsible. For example, one officer is responsible for physicians and family planning services.

Criteria used by administrative officers to approve or deny BR claims involves: 1) medical necessity of the item; 2) a prescription for the item; and 3) reasonableness of the cost. The claims are then returned to the fiscal agent where they are processed as approved or denied for payment. We reviewed the procedures followed by the administrative officers and a sample of actual BR claims. The action taken by the administrative officers and the process of review appeared reasonable.

During the audit, we wanted to determine how many by report claims needed authorization by the administrative officers of Medicaid Services Bureau. We found that records are not kept of the number of by report claims. Administrative officers estimated

the number of by report claims they approve or deny each month. The following illustration depicts the number of by report claims reviewed by the officers each month. The duties of one administrative officer do not require claim review responsibilities.

NUMBER OF BY REPORT CLAIMS REVIEWED EACH MONTH

Administrative Officer	BR Claims per Month
1	150-200
2	100-110
3	25-30
4	15-20
Total	290-360

Source: Bureau Administrative Officers

Illustration 10

Overall, the process used by SRS to review by report claims is satisfactory with the exception that records should be kept of the number and types of by report claims reviewed. We feel that it would be beneficial to keep records of the number and types of by report claims each administrative officer reviews. The State Medicaid Plan says a fee should be established for each BR procedure that is billed for 50 times in one year. The purpose of this provision is to allow for the establishment of a fee for those services which have become more common place and no longer need individual review; therefore, reducing the workload of the administrative officers. Keeping records would be beneficial to assure compliance with the plan and may eventually reduce work for the officers.

RECOMMENDATION #2
WE RECOMMEND THE BUREAU MONITOR THE NUMBER AND TYPES OF BY REPORT PROCEDURES REVIEWED BY THE ADMINISTRATIVE OFFICERS.

ALLOWABLE PROVIDER SERVICES

Services allowed by the state are detailed in the Administrative Rules of Montana. All services were initially input into MMIS at its inception. Updates are entered by the fiscal agent upon authorization by SRS. Changes in allowable services are infrequent. Work is currently being done to allow denturists to become Medicaid providers. This involves department review and approval and ultimately, funding by the legislature.

As a part of our questionnaire we asked providers for their opinions on services that should be added or deleted from Medicaid coverage. Additions and deletions were numerous and diversified. Several providers suggested that emergency services were abused and stricter eligibility criteria should be added before payment. Several providers also suggested the deletion of providing eyeglasses every two years for Medicaid recipients. Overall, about 25 percent of respondents to our questionnaire suggested additions and 12 percent suggested deletions for allowable Medicaid services.

Conclusion

From the responses to our survey, we believe that there is a need for the bureau to keep in contact with providers to obtain their views on allowable services. Bureau personnel should work closer with providers to help stay informed of provider concerns towards services provided. This relationship is discussed further in Chapter V of this report.

CHAPTER V

PROVIDER SERVICES

INTRODUCTION

Although the Medicaid Services Bureau sets allowable fees and rates, the fiscal agent provides a majority of the contact with providers. The fiscal agent is responsible for screening and approving provider applications, processing claims and distributing provider manuals.

Providers wishing to participate in the Medicaid program must submit an application to the fiscal agent for approval. The fiscal agent screens the applicant, including verification of licensure by appropriate licensing boards.

Our audit tests were directed at determining if communication among the Medicaid Services Bureau, fiscal agent, and providers is adequate and to see if provider requirements are adequately monitored by the Medicaid Services Bureau.

As a part of our audit we reviewed the provider application process and documented the role of the licensing boards in the process. We documented procedures used by SRS to review provider concerns and inform providers of rate changes and other needed information. We contacted a sample of active providers by questionnaire. We also contacted by telephone a sample of providers who were not enrolled in the Medicaid program. A majority of those providers not enrolled were retired or not providing services eligible for Medicaid reimbursement. Most of the providers in Montana are enrolled in the Medicaid program.

ENROLLMENT OF PROVIDERS

Provider enrollment is a responsibility of the fiscal agent. Contact can be made with the fiscal agent a number of ways. Telephone requests, letters, and referrals from SRS are frequent ways. However, the most common contact is made by submitting a claim to be paid by Medicaid.

After contact is made, the fiscal agent sends an application for enrollment to the requesting provider. Upon receipt of a

completed application, a confirmation is sent to the appropriate licensing board. After confirmation that the provider is licensed, a provider number is assigned and the provider is entered into the MMIS. Preaddressed and coded claim forms are sent to approved providers. Any preexisting claims can then also be processed. Enrollment usually takes approximately 30 days to complete.

The fiscal agent confirms all licenses annually to assure that providers on the active list continue to be licensed in the state.

During our audit we reviewed requirements and procedures used to enroll new providers. Also, a questionnaire was used to determine if providers were satisfied with the enrollment process. We found that requirements are reasonable and that the enrollment process is satisfactory. Questionnaire results show that over 86 percent of the providers were satisfied with the enrollment process. Approximately 8 percent did encounter problems and 6 percent did not respond.

Conclusion

We believe procedures used by the fiscal agent to enroll providers in the Medicaid program were adequate for the purpose intended. Currently new enrollment procedures have been established because of a change in fiscal agent. Procedures used by the new fiscal agent to enroll providers were not reviewed.

PROVIDER RATE NOTIFICATION

Fee-based providers are reimbursed for services rendered according to a fee schedule developed by Medicaid Services Bureau. As part of our audit work, we determined whether procedures used to notify providers of allowable rates were adequate.

The fiscal agent is responsible for notifying providers of allowable rates. Providers are furnished with manuals and any updates or rule changes. The fiscal agent records the date materials are sent to assure that no providers are missed. We reviewed the procedures used by the fiscal agent to supply providers with manuals and manual updates and found them to be adequate.

Conclusion

The process used by the fiscal agent to notify providers of needed rate information was satisfactory. The new fiscal agent has since mailed an updated manual with rate information to all active providers. We did not review the rate notification procedures used by the new fiscal agent.

DEPARTMENT'S ROLE IN PROVIDER RELATIONS

In our review of communication between providers and the fiscal agent and between providers and SRS, we found that some improvements could be made. The department's contact with providers is primarily reacting to provider problems and inquiries. SRS has given most of the responsibility for working with providers to the fiscal agent. In addition, based on our questionnaire, the department has reviewed less than 5 percent of provider office records. Because of the concerns raised earlier in the report and in our questionnaire, we believe SRS should initiate more contact with providers to improve the system.

SRS has no system to routinely collect provider information and comments. In Chapter IV we expressed our concerns with the need to collect information from providers on BR claims and their input regarding the rule regulating rate increases. We also discussed provider suggestions related to increasing or decreasing allowable Medicaid services. Some additional provider comments from our questionnaire related to timeliness of claims payment and identification of Medicaid recipients. About 31 percent of respondents said that reimbursement payments were not received within a reasonable time. Approximately 34 percent said they had problems identifying Medicaid recipients. Suggestions were made by providers to help control program abuse and lower Medicaid costs.

Results of the survey indicated that approximately 13 percent of the providers had never received manuals. A system of contacting a sample of providers periodically would ensure that manuals and updates were being received and other program requirements were being met. This system would also allow the collection of

information on provider concerns such as those discussed in the preceding paragraph.

We had 6 percent of our questionnaires returned because of incorrect addresses. In addition, about 14 percent of the respondents to our questionnaire indicated that they had not submitted any Medicaid claims within the last year. Several respondents indicated that they had retired. This would indicate that some provider names should be purged from the active provider list. The new fiscal agent has done this as a part of the new contract, but periodic contact with providers would tell SRS if it should be done again in the future.

As discussed above, the department's contact with providers is primarily reacting to provider problems and inquiries. We believe SRS should initiate more contact with providers to gain information on how to improve the Medicaid fee-based system.

RECOMMENDATION #3
WE RECOMMEND THE MEDICAID SERVICES BUREAU INITIATE MORE CONTACT WITH FEE-BASED PROVIDERS TO IMPROVE THE MEDICAID FEE-BASED SYSTEM.

AGENCY RESPONSE

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES

TED SCHWINDEN, GOVERNOR

STATE OF MONTANA

August 2, 1985

Jim Nelson, Audit Supervisor
Office of Legislative Auditor
State Capitol
Helena, MT 59601

Dear Mr. Nelson

Enclosed are the Department's responses to the recommendations pertaining to
management of the fee based providers component of the Montana Medicaid
Program.

We have concurred with the recommendations. The report and recommendations
will be useful in improved management of the Medicaid Services Bureau.

Thank you for your constructive report.

Sincerely,

Dave Lewis
Director

PCM/THD/018

Enclosures

RECOMMENDATION #1

Agency Response:

A.   The Department concurs that development of normal goals and objectives
     should be a high priority. The development of goals will be worked on,
     taking into account legislative mandate, federal laws and regulations.

B.   The Department concurs that the development of bureau policies and
     procedures are necessary and will be worked on as part of the on-going
     refinement of the management fee-based Medicaid services.

C.   The Department concurs with the need for performance evaluations. Com-
     pletion of employee evaluations within the Department's current personnel
     policies will be a priority.

D.   The Department concurs with the need for a reporting system to manage
     time. We will work on developing an approach for time management that
     both documents time worked and promotes efficient use of time.

E.   The Department concurs with the need for updated job descriptions and
     will work toward this goal as part of the employee evaluation effort.

RECOMMENDATION #2

Agency Response:

We concur with the need to establish fees for "By Report" Procedures (proce-
dures paid using "By Report" methodology).

The review of "By Report" procedures by administrative officers will be
expanded to include a fee setting function. The monitoring of the number and
types of "By Report" procedures will be considered during the updating of job
descriptions and employee evaluations.

RECOMMENDATION #3

Agency Response:

The Department concurs that contact with provider groups is necessary for
improved management of coverage and payment of fee-based provider services.
The Department will work towards expanding the contact with provider organiza-
tions beyond contacts around anticipated rule changes and problematic issues.

THD/018

APPENDICES

APPENDIX A

OFFICE OF THE LEGISLATIVE AUDITOR

MEDICAID: FEE-BASED SERVICES SURVEY QUESTIONNAIRE

Questionnaires were mailed to 736 fee-based providers with 478 questionnaires returned. Providers were asked to comment on many of the questions. Written comments were numerous and varied and are not listed in this appendix.

Summary of Responses (Percent)

Have you submitted claims to the Montana Medicaid program in the last year?

    84.8 yes   14.4 no   .8 no response

Did you encounter any problems when you applied for enrollment in the Montana Medicaid program?

    8.1 yes   86.3 no   5.6 no response

When you have questions involving Montana Medicaid patients, who do you contact for information?

16.9	Have not had any questions
29.4	Department of Social and Rehabilitation Services in Helena
43.1	County welfare office
45.0	Fiscal agent
10.0	Other

(Note: Some providers had more than one response.)

After you were approved as a Medicaid provider, how long did it take to get your provider manual?

14.6	Less than 30 days
15.0	31-60 days
2.1	61-90 days
1.5	More than 90 days
12.9	Never received a manual
43.1	Do not remember
10.8	No response

Instructions in the manual could be described as:

3.8	Very good
29.6	Good
26.0	Usable
2.7	Poor
2.1	Very poor
17.5	No opinion
18.3	No response

Updates to manuals (policy changes) are received on a timely basis.

25.6	Yes
8.4	No
28.5	Not sure
24.6	Have not received any updates
12.9	No response

Claim forms used for Medicaid could be described as:

59.2   Easy to use

3.8   Difficult to use

0.4   Do not contain enough information

9.4   Contains unnecessary information

16.3   No comment

10.0   Other

.9   No response

Are reimbursement payments received within a reasonable time?

45.6 yes   31.0 no   11.1 not sure   12.3 no response

On the average, Medicaid reimbursement amounts as a percentage of your normal billings amounts are:

4.6 100%   11.7 76-99%   32.1 50-75%

38.5 below 50%   13.1 No response

Are you able to collect co-payments for Medicaid services?

29.0 yes   29.6 no   41.4 no response

Have your office records ever been reviewed by the Department of Social and Rehabilitation Services or the Montana Foundation for Medical Care?

4.6   Yes, Department of Social and Rehabilitation Services

5.0   Yes, Montana Foundation for Medical Care

75.1   No

1.5   Both

13.8   No response

Are there services not covered by the Montana Medicaid program that you feel should be covered? (Specific responses were requested)

    24.6 yes   50.8 no   24.6 no response

Are there services covered by the Montana Medicaid program that you feel should not be covered? (Specific responses were requested)

    11.5 yes   61.0 no   27.5 no response

When a patient is treated, do you have problems identifying that patient as a Medicaid recipient?

    34.4 yes   54.1 no   11.5 no response

What problems do you encounter?

15.6   Out-dated Medicaid cards

18.5   Patients claim they lost their cards

3.3   Patients attempt to use another person's card

22.7   Patient has not received card

5.0   No problems encountered

20.0   Other

Please comment on any problems encountered with the administration of the Medicaid program in Montana.

2.1   Crossover claims (Medicare/Medicaid)

1.5   Co-payments

13.8   Eligibility or claims processing

3.5   Low reimbursement rates

11.0   Other

68.1   No response

Please make any suggestions to improve the relationship between providers and the state of Montana concerning the Medicaid program.

6.7   Raise fees

9.0   Abolish co-payments

1.5   Monitor program abuse

13.7   Other

69.1   No response

APPENDIX B

MEDICAID SERVICES

Listed below are the four mandatory fee-based Medicaid services and the 18 optional services provided by SRS. Also listed are the limits on each service as applied by SRS and recipient co-payments.

Mandatory Services

1. Laboratory and X-ray Services

   - Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice, or ordered by a physician but provided and billed by an independent laboratory.

   - Experimental services are not covered.

   - Recipients co-payment of $1.00 per service.

2. Family Planning Services and Supplies

   - Sterilization and abortion must meet federal regulations, which will allow payment of abortions only if the life of the mother is in danger.

3. Early and Periodic Screening, Diagnosis, and Treatment

   - Experimental services are not covered.

   - Limited to individuals under 21 years of age.

4. Physician Services

   - Sterilizations/abortions limited by federal regulations.

   - Experimental services are not covered.

   - Cosmetic services are not covered unless severe impairment to patient's psycho-social well-being is demonstrated and treatment has prior authorization.

   - Recipients co-payment of $1.00 per service.

Optional Services

1. Dental Services and 2. Dentures

- Extensive dental services must have prior authorization. (Extensive refers to crowns, bridges, dentures either partial or full, root canals and all orthodonture.)

- Experimental services are not covered.

- Recipients co-payment of $1.00 per service.

3. Prescription Drugs

- Prescribed by physician.

- Less-than-effective and experimental drugs are not covered.

- Recipients co-payment of $.50 per prescription.

4. Rehabilitative Services (Durable Medical Equipment and Supplies)

- Purchase of items which occur only rarely must be prior authorized.

- Rental charges may not exceed purchase price.

- Ordered by a physician.

- Experimental devices are not covered.

- Recipients co-payment of $.50 per service for items with a fee listed in the ARM. Those items requiring prior authorization require a $3.00 co-payment.

5. Podiatrists

- Experimental services are not covered.

- Recipients co-payment of $1.00 per service.

6. Optometrists and 7. Eyeglasses

- Eye examination limited to 1 annually.

- 1 pair of eyeglasses annually for individuals under 21.

- 1 pair of eyeglasses every 2 years for individuals 21 and over, unless there is a significant change in prescription or the individual has had cataract surgery.

- Experimental services are not covered.

- Recipients co-payment of $1.00 per service.

8. Physical Therapy   9. Speech Therapy and
10. Occupational Therapy

- Ordered by physician.

- Limited to 200 visits/hours per year.

- Experimental services are not covered.

- Recipients co-payment of $.50 per service.

11. Psychologist's Services

- Limited to 22 clinical hours per year.

- Collateral therapy with a parent is allowed for a child in active treatment. The time with the parent counts against the child's 22 hours.

- Experimental services including bio-feedback are not covered.

- Recipients co-payment of $.50 per service.

12. Personal Care Attendant Services

- Ordered by physician.

- Must be medically necessary.

- Supervised by an RN.

- No skilled nursing services.

- May not be provided in a long term care facility, including a personal care facility.

- Cost of care may not exceed 80 percent of nursing home care.

13. Private Duty Nursing Services

- Ordered by a physician.

- Prior authorization.

- Recipients co-payment of $.50 per service.

14. Clinic Services

- Under physician direction in a licensed facility for out-patients.

- Nursing home patients may be covered for mental health clinic services per approved agreement between center and nursing home.

- Recipients co-payment of $1.00 per service.

15. Hearing Aids and Audiology Services

  - Ordered by physician.

  - Hearing evaluation by audiologist required prior to purchase.

  - No replacements except for significant changes in hearing loss.

  - Experimental services are not covered.

  - Recipients co-payment of $.50 per service.

16. Medical Transportation

  - Ambulances must be licensed under state law.

  - Ambulances are covered for emergency care and for nonemergency care when the patient is stretcher-bound and the transport is ordered by a physician.

17. Prosthetic Devices

  - Ordered by physician.

  - Convenience and comfort items are not covered.

  - BR items need prior authorization.